Disability Rx Application

Complete this form, sign the second page, and return it to the address listed below.

Applicant Information *(Please Print)*

_____
Last Name, First Name, Middle Initial

_____ _____
Date of Birth *Social Security Number*

_____ _____
Medicare Number with letter (if any) *Medicare Effective Date (if any)*

_____
Medicare Prescription Drug Plan (if any)

_____ Male ☐ Female ☐
Monthly Part D Premium (if any)

Have you lived in Nevada continuously for 12 months prior to the date of this application? Yes ☐ No ☐

What is your disability _____

If you receive any help based on your disability, provide the agency name _____

Are your assets (excluding your home and car) less than $11,500 if single or $23,000 if married? Yes ☐ No ☐

List All Current Monthly Income Received

Type of Income	Applicant		Spouse		Total
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____
_____	_____	+	_____	=	_____

Total monthly income from all sources ……_____

(Income includes Social Security, SSI, Pensions/IRAs, Interest and Dividends, Wages, Real Estate Rental, and Others.)

Capital Gains (Loss) on last tax return _____

Business Income (Loss) on last tax return _____

Applicant Contact Information

Residence _____
Number, Street, Apt. or Space Number

Address _____
City, State, Zip Code

Mailing _____
Number, Street, Apt., Space Number or P.O. Box

Address _____
City, State, Zip Code

Telephone (____)_____

Alternate Telephone (_____)_____

Spouse Information *(Please Print)*

Are you applying for Disability Rx also? Yes ☐ No ☐
Even if not applying, please provide your name.

_____
Last Name, First Name, Middle Initial

_____ _____
Date of Birth *Social Security Number*

_____ _____
Medicare Number with letter (if any) *Medicare Effective Date (if any)*

_____
Medicare Prescription Drug Plan (if any)

_____ Male ☐ Female ☐
Monthly Part D Premium (if any)

Have you lived in Nevada continuously for 12 months prior to the date of this application? Yes ☐ No ☐

What is your disability _____

If you receive any help based on your disability, provide the agency name _____

Important Information About Your Application:

A. You do not need to attach income, age or disability verification to this application. However, you may be asked to provide such documentation at a later date.

B. Married couples need to submit only one application for both spouses.

C. You will be notified of eligibility status within 21 days of receipt of your application unless the Department of Health and Human Services needs to request additional information to process your application.

D. Sign this application on the back and mail it to: **State of Nevada**
Disability Rx
P.O. Box 21230
Carson City, NV 89721-9909

By signing this application, I agree to the following:

- To immediately provide to the Department of Health and Human Services written notice of a change of address, name, household income, marital status, telephone number, status of disability, and Medicaid, SSI or Medicare eligibility.
- If I received the benefit of the Disability Rx assistance and I was not eligible for the assistance, I will refund to the Department of Health and Human Services all amounts paid on my behalf.
- That as a condition of, and for purposes of determining eligibility for this program, I authorize the Department of Health and Human Services to verify my eligibility, including my income, and I will provide documentation of my disability upon request. This authorization is valid for a period of 14 months from the date of my signature below.

I declare that the information in this application for Disability Rx is accurate to the best of my knowledge and ability.

_____ _____

Applicant Signature *Spouse Signature*

_____ _____

Print Name *Date* *Print Name* *Date*

Authority: If I am eligible for Medicare Part D and I write my initials in the appropriate space below, I grant Disability Rx the authority to enroll me in the Part D plan that most closely matches my needs based on my medications, preferred pharmacy, and costs. I understand that I may not grant this authority if I am already a member of a retiree health plan, a Medicare managed care plan or a health maintenance organization.

_____ Applicant _____ Spouse

Please Note: *If someone other than the applicant or spouse signs, a copy (non-returnable) of a Power of Attorney or Letters of Guardianship must be attached.*

Disability Rx Questions? Call
1-866-303-6323

Medicare Part D questions? Call
1-800-Medicare
(1-800-633-4227)

For Statistical Purposes Only

Check one box for applicant and one box for spouse (if any)

☐ ☐ American Indian/Alaskan Native
☐ ☐ Hispanic ☐ ☐ African American
☐ ☐ White ☐ ☐ Asian/Pacific Islander

This information is voluntary and will be kept separate and confidential.

Confidentiality Statement

Information provided on this application is confidential. No person may publish, disclose or use any personal or confidential information contained on this application except for purposes connected to the administration of this program. Unauthorized disclosures are a violation of the Health Insurance Accountability and Portability Act (HIPAA) and may result in civil penalties.